N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REC'D JUN 9 1938

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space 16572

Registration District No. 791

Primary Registration District No. 1008

Registered No. 4433

1. PLACE OF DEATH

(a) County

(b) Township

(c) City St. Louis (d) Street No. City Hospital No. 1 St.
(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred 51 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

D.963

2. PRINT FULL NAME Patrick Ryan 500

(a) Residence, No. 5416 North Euclid St. 7
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Anna Ryan

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): May 4, 1868

7. AGE: Years 70 | Months — | Days 9 | If LESS than 1 day, ...hrs. or ...min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Union Electric

9. Industry or business in which work was done, as saw mill, bank, etc.: Retired

10. Date deceased last worked at this occupation (month and year): 1931

11. Total time (years) spent in this occupation:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Canada

FATHER

13. NAME: Mike Ryan

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ireland

MOTHER

15. MAIDEN NAME: Kate ?

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown

17. INFORMANT (ADDRESS): Hosp. Info M. Kent

18. BURIAL, CREMATION, OR REMOVAL
PLACE Calvary Cemetery DATE May 16, 38

19. FUNERAL DIRECTOR (NAME) Bromschwig Undertakers
(ADDRESS) 4746 West Florissant Ave.

20. FILED MAY 14 1938 J. D. Bredeck Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5/13/38, 19

22. I HEREBY CERTIFY, That I attended deceased from 4/19/38, 19 to 5/13/38, 19
I last saw him alive on 5/13/38, 19 Death is said to have occurred on the date stated above, at 9.15 a m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral hemorrhage	
Hypertensive heart disease	
Generalized arteriosclerosis	

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur?
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) R. C. Maxwell, M. D.
(Address) City Hospital No. 1

Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, Albert H Hopper, or by

Registered Apprentice No....., working under my personal supervision.

Signed Albert H Hopp

Licensed Embalmer No. 1861

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.